

**BEHAVIORAL HEALTH ASSESSMENT**

(Patient: Please provide the following information to assist your provider in making a complete evaluation.)

**PART 1 - IDENTIFICATION DATA****Section 1A - Patient Data**

Name: (Last, First, MI)				Home phone: (Including area code) May we contact you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		Today's date:			
Street address:				City:		State:		Zip code:	
Referred by: <input type="checkbox"/> Self <input type="checkbox"/> Command <input type="checkbox"/> Medical <input type="checkbox"/> Other:				Your social security number:		Work phone: (Including area code) May we contact you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Age:	Date of birth: (DDMMYY)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Am. Indian <input type="checkbox"/> Other:			Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other:			
Are you active duty or retired military? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," skip the rest of this section and proceed to Section 1B - Spouse Data.)									
Grade:	Branch of service: <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Coast Guard <input type="checkbox"/> Other:			Duty status: <input type="checkbox"/> Active duty <input type="checkbox"/> Retired: Date retired: _____					
Security clearance: <input type="checkbox"/> Top Secret <input type="checkbox"/> SCI <input type="checkbox"/> Secret <input type="checkbox"/> Confidential <input type="checkbox"/> None			Personnel Reliability Program: <input type="checkbox"/> Yes <input type="checkbox"/> No		Military occupational spec:		Job title:		
ETS: (DDMMYY)	Time in service:	Time in current unit:	Commander's/supervisor's name: (Last, First, MI)			Grade:	Work phone: (Including AC)		
Unit name, address, and phone number:									

**Section 1B - Spouse Data**

Name: (Last, First, MI)			Social security number:		Age:	Date of birth: (DDMMYY)		Race: <input type="checkbox"/> Blk <input type="checkbox"/> Wht <input type="checkbox"/> Hisp <input type="checkbox"/> Asian <input type="checkbox"/> Am Indian <input type="checkbox"/> Other:		
Home address: (If different than yours)							Home phone: (Including area code) (if different than yours)			
							Work phone: (Including area code)			
Is your spouse active duty or retired military? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," skip the rest of this section and proceed to Part 2 on the next page.)										
Grade:	Branch of service: <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Coast Guard <input type="checkbox"/> Other:			Duty status: <input type="checkbox"/> Active duty <input type="checkbox"/> Retired: Date retired: _____						
Security clearance: <input type="checkbox"/> Top Secret <input type="checkbox"/> SCI <input type="checkbox"/> Secret <input type="checkbox"/> Confidential <input type="checkbox"/> None			Personnel Reliability Program: <input type="checkbox"/> Yes <input type="checkbox"/> No		Military occupational spec:		Job title:			
ETS: (DDMMYY)	Time in service:	Time in current unit:	Commander's/supervisor's name: (Last, First, MI)			Grade:	Work phone: (Including AC)			
Unit name, address, and phone number:										

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## Part 2 - PRESENTING PROBLEM

a. What is (are) your reason(s) for coming in today?

b. Did anything happen within the last 24-72 hours which caused you to come in today? ☐ Yes ☐ No (If "Yes," please explain.)

c. How long have you been experiencing this (these) problem(s)?

d. Have you had difficulties or troubles like this before? ☐ Yes ☐ No (If "Yes," please explain.)

e. Please check all areas listed below which are current sources of increased stress for you.

☐ Marital ☐ Family ☐ Divorce ☐ Social ☐ Death ☐ Loss ☐ Medical ☐ Job ☐ Military ☐ Peers ☐ Legal ☐ Finances ☐ Trauma or abuse

☐ Alcohol problems ☐ Drug problems ☐ Alcohol or drug problems with someone other than yourself ☐ Relationships ☐ School

☐ Other: \_\_\_\_\_ ☐ Not applicable

## PART 3 - PHYSICAL ASSESSMENT

Date of last physical exam:

Name of primary care provider

Office phone: (Including area code) (If other than Fort Meade MEDDAC.)

a. Have you recently experienced, or do you presently have, any of the following symptoms? ☐ Dizziness ☐ Headaches ☐ Loss of appetite  
☐ Weight gain ☐ Weight Loss ☐ High blood pressure ☐ Back pain ☐ Injury ☐ Sexual problems ☐ Nicotine craving ☐ Major Illness ☐ Chest pain  
☐ Pregnancy ☐ Abnormal menstrual cycle ☐ Sore throat ☐ Bronchitis ☐ Stomach trouble ☐ Hearing problems ☐ Bloody stool or urine ☐ Fatigue  
☐ High energy ☐ Rapid pulse or breathing ☐ Slurred speech ☐ Numbness ☐ Eating problems ☐ Sleeping problems

☐ Other: \_\_\_\_\_

b. Are you undergoing treatment for any of the above? ☐ No ☐ Yes (If "Yes," please explain.)

c. List all allergies and reactions to medications:

d. List all past psychiatric medications and any current medications including over the counter medications, herbs and supplements: (This information will help us to accurately assess your overall health condition.)

Name of drug	Amount Taken (Dose)	Date Started	Date Stopped	Effectiveness

Date:

Patient's name: (Last, First, MI)

Patient's social security number:

Patient's date of birth:

**PART 3 - PHYSICAL ASSESSMENT (Continued)**

e. List all current and past medical or physical problems, including hospitalizations and traumas:

**PART 4 - PAIN ASSESSMENT**

a. Are you currently experiencing physical pain? ☐ Yes ☐ No If "no," please proceed directly to Part 5 on the next page.

b. Please answer questions (1) through (3) on a scale of 0 to 10, where 0 = No Pain and 10 = Worst Imaginable Pain (Please circle your choices below.)

(1) Please score your pain at its worst: 0 1 2 3 4 5 6 7 8 9 10 At its best? 0 1 2 3 4 5 6 7 8 9 10

(2) How bad has your pain been in the last 24 hours? 0 1 2 3 4 5 6 7 8 9 10

(3) What is your level of pain at rest? 0 1 2 3 4 5 6 7 8 9 10 With activity? 0 1 2 3 4 5 6 7 8 9 10

c. When is your pain at its worst?

d. Do you need to see your primary care manager about your pain? ☐ Yes ☐ No

**PART 5 - PSYCHOLOGICAL ASSESSMENT**

a. Have you recently experienced, or do you presently have any of the following? ☐ Stress ☐ Loss of interest in pleasurable activities ☐ Loss of energy  
☐ Difficulty concentrating ☐ Guilt ☐ Rage ☐ Mood swings ☐ Irritability ☐ Memory problems ☐ Panic or anxiety ☐ Depression ☐ Racing thoughts  
☐ Flashbacks ☐ Seeing visions ☐ Hearing voices ☐ Paranoia ☐ Nightmares ☐ Poor impulse control ☐ Feeling helpless or hopeless  
☐ Thoughts of hurting self ☐ Thoughts of hurting others

List any psychiatric or substance abuse evaluations, counselings and hospitalizations:

Reason	Location	Date treatment	Date treatment	Diagnosis (If known)

b. List any biological family members who have been diagnosed or treated for any of the following problems: ☐ Depression ☐ Anxiety ☐ Hyperactivity  
☐ Paranoia ☐ Manic episode(s) ☐ Bipolar disorder ☐ Schizophrenia ☐ Alcohol abuse ☐ Drug abuse ☐ Family violence ☐ Sexual abuse  
☐ Suicide (or attempted suicide)

Relationship	Problem/diagnosis	Hospitalized?	Medication prescribed (if known)
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

c. Have there been any deaths in your family related to the problems listed above? ☐ Yes ☐ No (If "Yes," please explain.)

Date: Patient's name: (Last, First, MI) Patient's social security number: Patient's date of birth:

**PART 6 - SUBSTANCE USE ASSESSMENT**

a. Are you experiencing any problems with alcohol or drugs at this time? ☐ No ☐ Yes (If "Yes," please explain.)

b. Did you ever find that you needed to drink a lot more or use more drugs in order to get an effect, or that you could no longer get high on the amount that you were using? ☐ Not applicable ☐ No ☐ Yes (If "Yes," please explain.)

c. Did you ever get into arguments or fights while drinking or using drugs? ☐ Not applicable ☐ No ☐ Yes (If "Yes," please explain.)

d. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or make yourself feel better? ☐ No ☐ Yes (If "Yes," please explain.)

e. Have you ever had times when you drank or used drugs to the point that you couldn't remember what you said or did the next day (i.e., blackouts)?  
☐ Not applicable ☐ No ☐ Yes -- How many times? \_\_\_\_\_ (If "Yes," please explain.)

f. Do you smoke or use tobacco products? ☐ No ☐ Yes If "Yes," --

(1) What do you smoke or use? \_\_\_\_\_ (2) How long have you been smoking or using tobacco products? \_\_\_\_\_

(3) How much do you use in a day? \_\_\_\_\_ (4) Have you attempted to quit? ☐ No ☐ Yes (If "Yes," how long did you quit?) \_\_\_\_\_

(5) Are you interested in quitting? ☐ No ☐ Yes

**PART 7 - EARLY FAMILY RELATIONSHIP ASSESSMENT**

a. Where were you born? b. Who raised you? c. Were you adopted? ☐ Yes ☐

d. If adopted, at what age? e. How many biological brothers do you have? f. How many stepbrothers do you have?

g. How many biological sisters do you have? h. How many stepsisters do you have? i. What number child were you?

j. What was it like in your childhood home? ☐ Loving ☐ Comfortable ☐ Supportive ☐ Chaotic ☐ Abusive ☐ Other:

k. How often did your parents argue? ☐ Rarely ☐ Sometimes ☐ Often l. Did your parents physically fight? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

m. How close were to to your father? n. How close were you to your mother?

o. What kind of discipline was used in your home?

p. Have you ever been physically abused? ☐ Yes ☐ No (If "Yes," please explain.)

q. Was your family? ☐ Poor ☐ Middle class ☐ Wealthy

Date: Patient's name: (Last, First, MI) Patient's social security number: Patient's date of birth:

## PART 8 - CURRENT FAMILY RELATIONSHIP ASSESSMENT

- a. Are you presently married? ☐ Yes ☐ No (If "No," skip questions b through h)
- b. How long have you been married?
- c. Are you the spouse of a military member? ☐ Yes ☐ No
- d. Are you and your spouse both active duty military? ☐ Yes ☐ No
- e. How long did you date your spouse before getting married?
- f. Are you currently living with your spouse? ☐ Yes ☐ No
- g. On a scale of 1 to 10, where 1 equals "poor" and 10 equals "perfect," please rate your satisfaction with your marriage: 1 2 3 4 5 6 7 8 9 10
- h. Are you having any current problems in your marriage? ☐ Yes ☐ No (If "Yes," please explain)

i. How many times have you been married? \_\_\_\_\_

Date of marriage	Date of divorce or death of spouse	Reason the relationship ended

j. If you still have a relationship with a former spouse, please explain:

k. Have you and/or any of your spouses ever been to counseling or any agency such as Child Protective Services or Family Advocacy because of physical, sexual, or emotional abuse? ☐ Yes ☐ No (If "Yes," who participated in the counseling; please explain.)

l. Please list all your children:

Child's name	Child's age	Child's gender	Is this a biological child or a stepchild?	Does this child currently reside with you?

Date:	Patient's name: (Last, First, MI)	Patient's social security number:	Patient's date of birth:
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### PART 8 - CURRENT FAMILY RELATIONSHIP ASSESSMENT (Continued)

m. Does anyone else reside in your household? ☐ Yes ☐ No (If yes, please list names, ages, and relationships.)

n. Do you have weapons in your home? ☐ Yes ☐ No (If "Yes," please check all that apply.)

☐ Handgun(s) ☐ Rifle(s) ☐ Hunting or combat knife/knives ☐ Other:

o. Are you having any problems with your children? ☐ Yes ☐ No (If "Yes," please explain.)

p. How do you discipline your children?

q. Are you presently having any problems with your in-laws or parents? ☐ Yes ☐ No (If "Yes," please explain.)

### PART 9 - SOCIAL SUPPORT ASSESSMENT

a. Do you have someone you can talk to when you have a problem? ☐ Yes ☐ No

b. How many close friends do you have? \_\_\_\_\_

c. Is there someone you would ask for help if you needed it? ☐ Yes ☐ No

d. Who would you say really cares about you? \_\_\_\_\_

e. Are you geographically isolated from your family and friends? ☐ Yes ☐ No

f. Are you having trouble in your relationships with family or friends? ☐ Yes ☐ No

g. Have you recently withdrawn from friends or family? ☐ Yes ☐ No

h. Do you belong to any groups or organizations that are supportive and helpful to you? ☐ Yes ☐ No (If yes, please explain.)

Date:

Patient's name: (Last, First, MI)

Patient's social security number:

Patient's date of birth:

## PART 10 - PERCEPTION OF OWN STRENGTHS AND WEAKNESSES

a. What do you like about yourself:

b. What do you dislike about yourself:

c. What special skills, talents and aptitudes do you have?

d. Are there any of the following areas you would like to change? ☐ Too easily influenced by others ☐ Too impulsive ☐ Uncertain of what I want  
☐ Have difficulty making decisions ☐ Don't express thoughts or feelings well ☐ Too easily angered ☐ Have trouble getting along with people

Please list anything else you are concerned about:

## PART 11 - SPIRITUAL/CULTURAL ASSESSMENT

a. What is your religious or spiritual affiliation?

b. Select all of the following that currently apply to you: ☐ Losing my earlier faith or religion ☐ Not going to church often enough  
☐ Not getting satisfactory answers from my faith or religion ☐ Needing to talk with chaplain or pastor ☐ None of the foregoing currently apply to me

c. How much is your religion or spirituality a source of strength and comfort to you? ☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

d. How important a part of your daily life is your religion or spirituality? ☐ None ☐ Not much ☐ Some ☐ Quite a bit ☐ A great deal

e. Has your present problem or illness affected your religious or spiritual life? ☐ Yes ☐ No (If "Yes," how?)

f. Do you belong to any special groups that relate to your ethnic background or nationality, or political or spiritual beliefs? ☐ Yes ☐ No (If "Yes," please explain.)

g. Do you have any religious or spiritual practices that the provider needs to be aware of during treatment? ☐ Yes ☐ No (If "Yes," please explain.)

Date:

Patient's name: (Last, First, MI)

Patient's social security number:

Patient's date of birth:

## PART 12 - EDUCATIONAL ASSESSMENT

a. Highest level of education completed: ☐ Elementary school ☐ Junior high school ☐ High school ☐ Technical school ☐ Some college  
☐ 2-yr college degree ☐ 4-yr college degree ☐ graduate school ☐ Other:

b. Are you currently in school? ☐ Yes ☐ No (If "Yes," how has your problem impacted your performance?)

c. Did you repeat any grades? ☐ Yes ☐ No (If "Yes," please explain?)

d. Did you skip any grades? ☐ Yes ☐ No (If "Yes," please explain?)

e. Did you ever have problems reading? ☐ Yes ☐ No (If "Yes," please explain?)

f. Were you ever in any special education/gifted classes? ☐ Yes ☐ No (If "Yes," please explain?)

g. Did you ever have any disciplinary problems in school? ☐ Yes ☐ No If yes, were you ever suspended or expelled? ☐ Yes ☐ No (If "Yes," to the first or second question, please explain.)

h. How do you learn best? ☐ Seeing ☐ Hearing ☐ Experiencing (i.e., hands on)

Date:	Patient's name: (Last, First, MI)	Patient's social security number:	Patient's date of birth:
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### PART 13 - LEGAL ASSESSMENT

a. Have you ever been arrested? ☐ Yes ☐ No (If "Yes," please give year and reason.)

b. Are you currently on probation or parole? ☐ Yes ☐ No (If "Yes," please give the name of your probation or parole officer.)

c. Do you presently have any other legal problems? ☐ Yes ☐ No (If "Yes," please explain.)

d. (Military only) Have you ever had any administrative actions taken against you? ☐ Yes ☐ No (If "Yes," please select all that apply.)  
☐ Negative counseling statement ☐ Letter of reprimand ☐ Article 15 ☐ Courts-martial ☐ Chapter

### PART 14 - SEXUAL ASSESSMENT

a. Are you experiencing any sexual concerns? ☐ Yes ☐ No (If "Yes," please explain.)

b. My sex life is ☐ Good ☐ Fair ☐ Poor ☐ Abstinent

c. Have you ever been sexually abused? ☐ Yes ☐ No (If "Yes," at what age and by whom?)

d. Have you ever been sexually abusive to others? ☐ Yes ☐ No (If "Yes," please explain.)

e. Do you feel guilty about any past sexual experiences? ☐ Yes ☐ No (If "Yes," please explain.)

f. Have you ever had an unwanted pregnancy? ☐ Yes ☐ No ☐ Not applicable (If "Yes," please explain.)

g. Has any past or current sexual behavior gotten you into trouble? ☐ Yes ☐ No ☐ Not applicable (If "Yes," please explain.)

Date:	Patient's name: (Last, First, MI)	Patient's social security number:	Patient's date of birth:
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## PART 15 - LEISURE, RECREATIONAL AND VOCATIONAL ASSESSMENT

a. What is your present job?

b. Are there any problems with your present job?

c. Job history: *(Select all that apply to you.)* ☐ I have had no career problems

☐ Not working in the field I was trained in ☐ Wondering if I should change jobs ☐ Not liking the people I work with ☐ Combining marriage and a career  
☐ Needing career assistance ☐ Not getting promoted ☐ Not liking my supervisor ☐ Experiencing prejudice at work ☐ Lacking experience for a different job ☐ Other career or job problems:

d. If military, what are your plans: ☐ Stay in and reenlist ☐ Stay in until my ETS ☐ Get out ASAP with a good discharge ☐ Get out ASAP with any discharge

e. If military or a federal civilian employee,

(1) What was your usual job or occupation prior to entering government service? \_\_\_\_\_

(2) What was the longest period of time you held a job prior to entering government service? \_\_\_\_\_

f. Which of the following do you do? *(Select all that apply to you.)*

☐ Spend time with friends ☐ Sports or exercise ☐ Classes ☐ Dancing ☐ Time with family ☐ Hobbies ☐ Work part-time ☐ Watch movies or TV  
☐ Go "downtown" ☐ Stay at home ☐ Listen to music ☐ Spend time at clubs or bars ☐ Dancing ☐ Other:

g. What limits your leisure and recreational activities?

## PART 16 - NUTRITIONAL ASSESSMENT

a. Do you drink caffeinated beverages? ☐ Yes ☐ No *(If "Yes," how many and what type )*

b. Do you have 3 or more drinks of beer, liquor or wine almost every day? ☐ Yes ☐ No

c. In the last month, have you gained or lost 10 or more pounds without trying? ☐ Yes ☐ No *(If "Yes," please explain.)*

d. Have you ever had problems with your weight in the past? ☐ Yes ☐ No *(If "Yes," please explain.)*

e. Have you ever had problems with binge eating or compulsive overeating? ☐ Yes ☐ No *(If "Yes," please explain.)*

f. Have you ever had problems with purging (i.e., making yourself vomit)? ☐ Yes ☐ No *(If "Yes," please explain.)*

g. Are you experiencing frequent nausea and vomiting of more than 3 days duration? ☐ Yes ☐ No *(If "Yes," please explain.)*

Date:

Patient's name: *(Last, First, MI)*

Patient's social security number:

Patient's date of birth:

**PART 16 - NUTRITIONAL ASSESSMENT (Continued)**

h. Do you experience difficulty chewing or swallowing that causes you to eat less than normal amounts of food? ☐ Yes ☐ No (If "Yes," please explain.)

i. Are you experiencing diarrhea or constipation for more than 3 days? ☐ Yes ☐ No (If "Yes," please explain.)

j. Are you experiencing any other nutritional problems not asked in this section? ☐ Yes ☐ No (If "Yes," please explain.)

**PART 17 - FINANCIAL ASSESSMENT**

a. Who handles finances in your home?

b. Do you currently have any financial problems? ☐ Yes ☐ No (If "Yes," please explain.)

c. Do you think you need financial counseling? ☐ Yes ☐ No

d. Have you ever had any of the following problems? (Select all that apply to you.)

☐ Garnished wages ☐ Having "no pay due" ☐ Filed bankruptcy ☐ No money for food ☐ Bounced checks ☐ Had to pawn items to make ends meet  
☐ Received financial counseling ☐ Been disciplined for bad debts ☐ Had items repossessed ☐ Been late on payments/loans

**PART 18 - PATIENT DISCLOSURE**

Please use this space to tell us anything additional that you may feel is relevant or that may be important for your provider to know.

Patient's signature

Date:

Patient's name: (Last, First, MI)

Patient's social security number:

Patient's date of birth:

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## PROVIDER ASSESSMENT

### PART 19 - MENTAL STATUS EXAM

(Select all that apply and make notes as appropriate.)

#### BEHAVIORAL ASPECTS

##### Appearance:

Hygiene: ☐ Clean ☐ Dirty ☐ Well groomed ☐ Oily hair ☐ Odor ☐ Excess perfume or cologne

Age: ☐ Looks stated age ☐ Looks younger than stated age ☐ Looks older than stated age

Physical features:

Build: ☐ Small ☐ Medium ☐ Large

Tattoos: \_\_\_\_\_

Scars: \_\_\_\_\_

Other: \_\_\_\_\_

##### Alertness:

Orientation: Person ☐ Yes ☐ No Place ☐ Yes ☐ No Date ☐ Yes ☐ No Circumstance ☐ Yes ☐ No

Alert: ☐ Yes ☐ No ☐ Drowsiness ☐ Sleepiness ☐ Stupor ☐ Comatose ☐ Unresponsive ☐ Groggy ☐ Drugged

Attention: ☐ Maintains focus ☐ Distracted ☐ Unaware ☐ Inattentive ☐ Ignores question ☐ Attention not sustained

Concentration: ☐ WNL ☐ Serial 7's from 100 ☐ Serial 3's from 100 ☐ Easily completed ☐ Slight difficulty ☐ Moderate difficulty  
☐ Extreme difficulty ☐ Unable to complete

**Behavior:** ☐ No peculiarities noted ☐ Twitches ☐ Tics ☐ Stereotypical movements ☐ Posturing ☐ Hand wringing ☐ Tapping foot  
☐ Picking at hands ☐ Trembling

##### Speech:

Volume: ☐ WNL ☐ Loud ☐ Medium ☐ Low ☐ Monotone ☐ Inaudible

Rate: ☐ WNL ☐ Rapid ☐ Pressured ☐ Hesitant ☐ Latent (Delay in responding to and initiating speech.)

Coherence: ☐ WNL ☐ Slurred ☐ Garbled

Tone: ☐ WNL ☐ Friendly ☐ Angry ☐ Sad ☐ Soft

**Attitude:** ☐ Cooperative ☐ Hostile ☐ Open ☐ Secretive ☐ Involved ☐ Apathetic ☐ Evasive ☐ Seductive ☐ Guarded

**Memory:** Intact: ☐ Yes ☐ No

Remote: Can you name the last four presidents?

Recent: What did you have for dinner today?

Immediate: (Grasshopper, Chicago, Orange), (Joe Brown, 69 Maple Street, Chicago, Illinois), (Pencil, Car, Watch)

##### Mood and Affect:

Mood: ☐ Euthymic ☐ Elevated ☐ Irritable ☐ Happy ☐ Depressed ☐ Anxious ☐ Angry

Affect: ☐ Broad range ☐ Tearful ☐ Sobbing ☐ Flat ☐ Labile ☐ Restricted ☐ Inappropriate ☐ Mood congruent

**Perceptual Disturbances:** ☐ Yes ☐ No ☐ Hallucinations ☐ Illusions ☐ Depersonalization ☐ Derealization ☐ Ideas of reference

Date:	Patient's name: (Last, First, MI)	Patient's social security number:	Patient's date of birth:
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## PART 19 - MENTAL STATUS EXAM (Continued)

(Select all that apply and make notes as appropriate.)

### BEHAVIORAL ASPECTS (Continued)

#### Thought Processes and Content:

Thought Processes: ☐ Linear ☐ Logical ☐ Goal directed ☐ Tangential ☐ Circumstantial ☐ Flight of ideas ☐ Perserveration ☐ Clanging  
☐ Echolalia ☐ "Word salad"

Thought Content: ☐ WNL ☐ Suspicious ☐ Obsessions ☐ Phobias ☐ Rituals ☐ Delusions ☐ Thought insertion ☐ Thought removal  
☐ Ideas of reference ☐ Ideas of influence

#### Abstract Thinking:

Similarities: Baseball -- Orange      Sun -- Moon      Car -- Train      Tree -- Butterfly      Desk -- Bookcase

Proverbs: "A rolling stone gathers no moss."      " People who live in glass houses shouldn't throw stones."

Does the patient have thoughts of suicide? ☐ Yes ☐ No (If "Yes," explain.)

Does the patient have thoughts of homicide? ☐ Yes ☐ No (If "Yes," explain.)

Insight: ☐ Good ☐ Fair ☐ Poor (Explain)

Judgement: ☐ Good ☐ Fair ☐ Poor (Explain)

#### Neurovegetative Symptoms:

S: Sleep--

I: Interest--

G: Guilt--

E: Energy--

C: Concentration--

A: Appetite--

P: Psychomotor--

S: Sex drive--

Date:	Patient's name: (Last, First, MI)	Patient's social security number:	Patient's date of birth:
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**PART 19 - MENTAL STATUS EXAM (Continued)**

*(Select all that apply and make notes as appropriate.)*

**BEHAVIORAL ASPECTS (Continued)**

**Mental Status Notes:** *(Explanations)*

Date:	Patient's name: <i>(Last, First, MI)</i>	Patient's social security number:	Patient's date of birth:
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PART 20 - DIAGNOSTIC SUMMARY (NARRATIVE SECTION)			
Date:	Patient's name: ( <i>Last, First, MI</i> )	Patient's social security number:	Patient's date of birth:

Patient's date of birth:
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**PART 21 - SIGNIFICANT OTHER INFORMATION**  
(Collateral Contacts)

a. Supervisor's/commander's perception of the problem:

b. Family's perception of the problem:

c. Other information: *(Police, CID, neighbor, primary case manager, etc.)*

**PART 22 - DIAGNOSIS**

AXIS I

AXIS II

AXIS III

AXIS IV

AXIS V   GAF = \_\_\_\_\_ currently

Strengths:

Weaknesses:

Potential barriers to treatment:

Date:

Patient's name: *(Last, First, MI)*

Patient's social security number:

Patient's date of birth:

**PART 23 - PROVIDER NOTES**

- a. Check answers to questions "c" and "g" through "i" in Part 16 (Nutrition Assessment) for possible referral to Nutrition Care.
- b. If any questions in Part 6 (Substance Abuse Assessment) are answered "Yes," refer to the Army Substance Abuse Program Counseling Center.
- c. If any financial problems are identified in Part 16 (Financial Assessment), refer to Army Community Service.

**PART 24 - PLAN**

1.

2.

3.

Next appointment is scheduled with \_\_\_\_\_ at \_\_\_\_\_ on \_\_\_\_\_.

Provider's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's notes:

Supervisor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date:	Patient's name: <i>(Last, First, MI)</i>	Patient's social security number:	Patient's date of birth:
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